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10 CFR 50.73

ComEd

June 2, 2000

PSLTR: #00-0089

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, DC 20555

Dresden Nuclear Power Station, Unit 3
Facility Operating License No.DRP-25
NRC Docket No. 50-249

Subject: Licensee Event Report 2000-002-00, "Reactor SCRAM Caused by Failure to Use Correct Procedural Acceptance Criteria"

The enclosed Licensee Event Report, which is a final report, describes the Reactor SCRAM caused by failure to use correct procedural acceptance criteria due to human error by an Electrical Maintenance Department (EMD) individual. This condition is being reported pursuant to 10 CFR 50.73 (a)(2)(iv), which requires the reporting of any event or condition that resulted in a manual or automatic actuation of any Engineered Safety Feature (ESF), including the Reactor Protection System (RPS).

The following actions were taken:

Counseled EMD individual regarding the importance of Self-Checking.

As an interim measure, until the EMD error prevention culture has been increased, the recently appointed Maintenance Department Human Performance Coordinator will work specifically with the EMD shop, First Line Supervisors (FLSs) and Superintendent on human error prevention.

The correspondence contains the following commitments:

Implement the INPO Error Prevention Model to EMD Craft, EMD FLSs, and EMD Superintendents so that it may be incorporated into the thought process and human error prevention culture of EMD. This process will be used in Pre Job Briefs to identify what items will keep them from being successful at performing their jobs so that verifications can be performed prior to releasing the package to operations.

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If you have any questions, please contact Dale Ambler, Dresden Regulatory Assurance Manager at (815) 942-2920 extension, 3800.

Respectfully,

Preston Swafford
Site Vice President
Dresden Nuclear Power Station

Enclosure

cc: Regional Administrator – NRC Region III
NRC Senior Resident Inspector – Dresden Nuclear Power Station

NRC FORM 366 (6-1998) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 06/30/2001

Estimated burden per response to comply with this mandatory information collection request: 50 hrs. Reported lessons learned are incorporated into the licensing process and fed back to industry. Forward comments regarding burden estimate to the Information and Records Management Branch (t-6 f33), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, and to the Paperwork Reduction Project (3150-0104), Office Of Management And Budget, Washington, DC 20503. If an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

LICENSEE EVENT REPORT (LER)

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TITLE (4)
Reactor SCRAM Caused by Failure to Use Correct Procedural Acceptance Criteria

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
									N/A	N/A
05	03	2000	2000	002	00	06	02	2000	FACILITY NAME N/A	DOCKET NUMBER N/A

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more) (11)							
POWER LEVEL (10)	100		20.2201(b)		20.2203(a)(2)(v)		50.73(a)(2)(i)		50.73(a)(2)(viii)
			20.2203(a)(i)		20.2203(a)(3)(i)		50.73(a)(2)(ii)		50.73(a)(2)(x)
			20.2203(a)(2)(i))		20.2203(a)(3)(ii)		50.73(a)(2)(iii)		73.71
			20.2203(a)(2)(ii)		20.2203(a)(4)	X	50.73(a)(2)(iv)		OTHER
			20.2203(a)(2)(iii)		50.36(c)(1)		50.73(a)(2)(v)		Specify in Abstract below or in NRC Form 366A
			20.2203(a)(2)(iv)		50.36(c)(2)		50.73(a)(2)(vii)		

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
Timothy P. Heisterman, Licensing Engineer	(815) 942-2920 ext 3324

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

SUPPLEMENTAL REPORT EXPECTED (14)				EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
	YES (If yes, complete EXPECTED SUBMISSION DATE).	X	NO				

ABSTRACT (Limit to 1400 spaces, i. e., approximately 15 single-spaced typewritten lines) (16)

On May 3, 2000, at 0946 hours, Dresden Operating Department began to transfer the "B" Reactor Protection System (RPS) Bus from its Normal Power Supply to its Reserve power supply per station procedure DOP 0500-03, "Reactor Protection System Power Supply Operation." The "3A" MG Set Drive Motor feeds the "3B" RPS bus. During this evolution, the breaker to the "3B" MG Set Drive Motor (hence "3A" RPS Bus) tripped on thermal overloads causing a loss of the "3A" RPS Bus and an automatic reactor SCRAM.

The cause for the "3B" MG Set Drive Motor breaker tripping on thermal overloads was due to the breaker thermal overload trip setpoint being set too low due to the wrong acceptance criteria utilized by the electrician during the performance of a preventive maintenance activity. The reason for not identifying the wrong acceptance criteria prior to returning the breaker to service was failure to verify acceptance criteria.

The safety significance of this event was minimal. All safety systems operated as designed and all ECCS systems were available to mitigate the consequences of an accident.

PLANT AND SYSTEM IDENTIFICATION:

General Electric - Boiling Water Reactor - 2527 MWt rated core thermal power

Energy Industry Identification System (EIIS) Codes are identified in the text as [XX] and are obtained from IEEE Standard 805-1984, IEEE Recommended Practice for System Identification in Nuclear Power Plants and Related Facilities.

EVENT IDENTIFICATION:

Reactor SCRAM Caused by Failure to Use Correct Procedural Acceptance Criteria

A. PLANT CONDITIONS PRIOR TO EVENT:

Unit: 03 Event Date: 05-03-2000 Event Time: 0946
Reactor Mode: 1 Mode Name: Run Power Level: 100 %
Reactor Coolant System Pressure: 1002 psig

B. DESCRIPTION OF EVENT:

This LER is being submitted pursuant to 10 CFR 50.73 (a)(2)(iv), which requires within 30 days after the discovery of the event, the licensee shall report any event or condition that resulted in a manual or automatic actuation of any engineered safety feature (ESF), including the reactor protection system (RPS).

On May 3, 2000, at 0934 hours, Dresden Operating Department successfully transferred the "A" RPS [JC] Bus feed to the Normal Power Supply from the Reserve Power Supply per DOS 0500-03, "Reactor Protection System Power Supply Operation. " This transfer of power supplies was required to restore the system to its normal line up after performing Preventative Maintenance (PM) on the RPS system which included work on the "B" MG Set Drive Motor Breaker.

On May 3, 2000, at 0946 hours, Dresden Operating Department began to transfer the "B" RPS Bus from its Normal Power Supply to its Reserve power supply per DOP 0500-03. Since the transferring of the power supply requires a "Dead Bus Swap", an expected half SCRAM occurred when the Normal Power Supply was removed from the "B" RPS Bus. Prior to transferring the Reserve Power Supply, and resetting the half SCRAM, the breaker to the "B" MG Set Drive Motor tripped causing a loss of the "A" RPS Bus and a reactor SCRAM. A Non Licensed Operator (NLO) and member of the Operational Analysis Division (OAD) were dispatched to breaker feeding the 3B RPS MG Set Drive Motor, to investigate the cause for the tripped breaker. The team reported that the breaker's thermal overloads were found tripped.

The safety significance of this event was minimal. All safety systems operated as designed and all ECCS systems were available to mitigate the consequences of an accident.

No other systems, components or structures were identified which contributed to the isolation event.

C. CAUSE OF EVENT:

The cause for the "3B" MG Set Drive Motor breaker tripping on thermal overloads was due to the breaker thermal overload trip times being set too low when the breaker was returned to service. The reason the breaker was returned to service with the overload trip times being set too low was due to the wrong acceptance criteria being utilized by the electrician during the performance of a preventive maintenance activity. (NRC Cause Code A)

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TEXT *(If more space is required, use additional copies of NRC Form 366A) (17)*

D. SAFETY ANALYSIS

The safety significance of this event is limited to the unnecessary plant transient through the operating modes. All safety systems operated as designed and all ECCS systems were available to mitigate the consequences of an accident. No engineered safety systems were needed in response to this event with exception of the expected automatic isolations designed to occur following a SCRAM, therefore the safety significance of this event was minimal.

E. CORRECTIVE ACTIONS:

Corrective Actions Completed:

Counseled EMD Individual regarding the importance of Self-Checking.

As an interim measure, until the EMD error prevention culture has been increased, the recently appointed Maintenance Department Human Performance Coordinator will work specifically with the EMD shop, FLSs and Superintendent on human error prevention.

Corrective Actions to be Completed:

Implement the INPO Error Prevention Model to EMD Craft, EMD FLSs, and EMD Superintendents so that it may be incorporated into the thought process and human error prevention culture of EMD. This process will be used in Pre Job Briefs to identify what items will keep them from being successful at performing their jobs so that verifications can be performed prior to releasing the package to operations. (ATI 21024-24)

F. PREVIOUS OCCURRENCES:

None

G. COMPONENT FAILURE DATA:

N/A